STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE SECOND ASSESSMENT YEAR	)))))	BRIEF OF THE MAINE AUTOMOBILE DEALERS ASSOCIATION INSURANCE TRUST
DOCKET NO. INS-06-900	)	

NOW COMES the Maine Automobile Dealers Association Insurance Trust (the "Trust"), by and through its undersigned counsel, and, pursuant to the Superintendent's Notice of Pending Proceeding and Hearing dated April 26, 2006, and his Procedural Order dated June 15, 2006, submits the following brief.

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INTRODUCTION

The Dirigo Health Agency Board of Directors (the "Board") is, quite frankly, self-absorbed. As shown below, the Board cares not about the process, its own orders, the rights of the Intervenors, or even the statute to which it owes its very existence—it cares only about advancing its agenda. Indeed, it took an order of the Superior Court for the Board to hold its hearing despite the fact that Legislature commanded it in the clearest terms possible to hold the hearing and make a determination of aggregate measurable cost savings ("AMCS") "not later than April 1st."

The Board ultimately made an AMCS Determination that would at first blush appear to be favorable to the Intervenors—reducing by nearly $60 million the AMCS sought by the Dirigo Health Agency ("DHA"). However, even a cursory review of the Board's deliberations reveals that the Board reduced the DHA's AMCS request, not because of an abiding conviction as to the correctness of the result, but rather in a belief that doing so would enhance its credibility and result in an easier figure to justify before the Superintendent and, ultimately, the courts. (Record at 5259-60, 5263). Given the fact that it reduced only a cost savings category having absolutely no basis, the Board's action is simply a craven attempt to *appear* reasonable by reducing the DHA's request.

Narcissus meets Machiavelli.

THE STATUTE

To provide funding to subsidize the DHA, the Dirigo Health Act, 24-A M.R.S.A. § 6901, *et seq.* (the "Act"), authorizes the Board to establish annually a so-called "savings offset payment" to be paid by health insurance carriers, employee benefit excess insurance carriers, and third-party administrators. See 24-A M.R.S.A. § 6913(2). Such savings offset payments may

not exceed either 4% of paid claims, or the amount of "aggregate measurable cost savings." See 24-A M.R.S.A. §§ 6913(2)(C) and 6913(3)(B).

The Act defines "aggregate measurable cost savings" to mean all savings, "including any reduction or avoidance of bad debt and charity care costs to health care providers in this state as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." 24-A M.R.S.A. § 6913(1)(A). Responsibility for determining AMCS resides, in the first instance, with the Board. See 24-A M.R.S.A. § 6913(1). Under the Act, the Board was required to make its AMCS determination "not later than April 1st."

THE PROCEEDINGS BEFORE THE BOARD

On January 27, 2006, the Board issued a Notice of Pending Proceeding and Hearing initiating an adjudicatory hearing on the determination of AMCS for the Second Assessment Year. (Record at 1-2). By Orders dated February 17, 2006 and March 6, 2006, the Board granted intervenor status in the proceeding to the Trust, Anthem Health Plans of Maine, Inc. ("Anthem"), the Maine State Chamber of Commerce (the "Chamber"), the Maine Association of Health Plans ("MEAHP"), and Consumers for Affordable Health Care ("CAHC"). (Record at 32-34, 55-56). The Board has conducted itself in the finest tradition of the proverbial tribunal of marsupials.

I. THE ORDEAL OF ACTUALLY HOLDING A HEARING.

The Board originally set an unworkable schedule for this proceeding to which the Intervenors objected. (Record at 7-9, 13, 17-18, 23-26, 28-29, 544-45). While it ultimately provided some measure of relief in Procedural Order No. 3 (Record at 42), the Board nevertheless saw fit to lecture the Intervenors on the sanctity of the April 1 deadline:

> The schedule is driven by the short time frame the Legislature has established for the Board to make a determination of aggregate measurable cost savings;

> informed by the fact that the proceeding comes on the heels of an adjudicatory hearing before the Superintendent of Insurance in October 2005; and the familiarity of all interested persons with the issues presented.
>
> With regard to the charge of the [Intervenors] that parties have not been given enough time to prepare a case, the Board notes that the Dirigo Act as originally enacted in 2003 included the requirement that the Board, after an adjudicatory hearing, make a determination of aggregate measurable cost savings not later than April. This provision was carried over into Chapter 400. [The Intervenors] were members of, or attended the meetings of, the Working Group and were parties to proceedings before the Superintendent in October 2005. [The Intervenors], therefore, have had more than sufficient notice that the Board would be holding an adjudicatory hearing prior to April of 2006.

(Record at 36).

Thereafter, on March 7, 2006, the DHA moved to continue the hearing, suggesting that it was unable to proceed due to the purported unavailability of information critical to the AMCS determination until July 1, 2006. (Record at 59-60, 165-71). The Board considered the motion at a meeting held on March 27, 2006, and at that time voted, the statute be damned, to grant the DHA's motion to continue the proceeding and to hold a hearing "not later than August 15, 2006." (Record at 1024-26, 5270-74).

The Trust, Anthem, the Chamber, and the MEAHP filed a Petition for Review of Refusal of Agency to Act on March 30, 2006, seeking, *inter alia,* an Order by the Superior Court compelling the Board to hold its adjudicatory hearing and make its AMCS determination forthwith. (Record at 522-61). Following briefing by the parties and a non-testimonial hearing, the Superior Court (*Marden, J.*) entered an Order on April 14, 2006, ordering the Board to make its AMCS determination on or before May 12, 2006. (Record at 671-79).

The Board ultimately held an evidentiary hearing over two days on May 8 and May 10, 2006. (Record at 4973, 5092, 5130). On May 12, 2006, the Board conducted its public deliberations. (Record at 5197).

II. THE BOARD LETS THE DHA AND CAHC IGNORE ITS ORDERS WITHOUT REPERCUSSION.

Unlike the Intervenors, who complied with all of the Board's deadlines, the DHA and its ally, CAHC, repeatedly ignored them. The DHA and the CAHC failed to designate their witnesses/exhibits or their proposed methodologies by the March 10 and 13 deadlines for doing so. (Record at 5284). After being ordered by the Board's Hearing Officer to produce their pre-filed testimony, exhibits, and methodologies by 5:00 p.m. on March 20, 2006 (at the time only one week before the scheduled start of the hearing) (Record at 42, 1002, 1006, 1007), the Intervenors received pre-filed testimony and a proposed methodology so incomplete as to be useless.

Following the Superior Court's Order alluded to above, and an Order of the Board's Hearing Officer dated April 28, 2006 (Record at 1032-33, 5285-86), the DHA filed supplemental pre-filed testimony on May 1, 2006, and filed a supplemental report from Mercer Government Human Services Consulting ("Mercer") on May 2, 2006 (Record at 1035-1177), less than a week before the May 8, 2006 start of the hearing.

The Board denied the Intervenors the opportunity to conduct discovery and relegated them to the Freedom of Access Act, 1 M.R.S.A § 401, *et seq*. ("FOAA"), process to obtain the most basic information about the DHA's case. (Record at 36, 46-54, 58). The Intervenors did not get any documents responsive to their requests until March 16, 2006. (Record at 172-76) The DHA's response, to be kind, was incomplete. The DHA's consultant, Mercer, felt that it was its purview to dictate which documents would and would not be produced and when they would be produced. (Record at 4913-40). Indeed, although the information on which Mercer relied in preparing its methodology was requested by the Intervenors in their FOAA requests, and was ordered by the Hearing Officer to be produced by 5:00 p.m. on May 2, 2006 (Record at

1033) ("This information shall include Mercer's calculation of the AMCS and all documents considered, reviewed, or relied upon for the report."), the Intervenors actually received the Medicare Cost Reports on which Mercer relied (consisting of approximately 1,500 pages) on the morning of May 9, 2006 (Record at 1465-2921), giving them all of one day to digest the information before the hearing resumed.

III. THE BOARD'S AMCS DETERMINATION

During its deliberations, the Board found AMCS totaling $41.5 million. Included within the AMCS determined by the Board were savings attributable to:

a. Hospitals voluntarily limiting cost increases to 4.5% as measured by expenses per Case Mixed Adjusted Discharge ("CMAD") ($14.2 million);

b. Avoidance or reductions in bad debt and charity care ("BD/CC") ($2.7 million);

c. The MaineCare Adults Expansion and so-called "Woodwork Effect" ($3.9 million);

d. Reduced spending on hospital and non-hospital infrastructure as a result of a Certificate of Need moratorium and limits on the Capital Investment Fund ("CON/CIF") ($5.5 million);

e. The time value of money stemming from accelerated payments of increased Prospective Interim Payments ("PIP") ($7.0 million); and

f. Increased Medicaid payments to be made to physicians in the future ($8.2 million).

(Record at 5213-15, 5219, 5223, 5229, 5235, 5238-39, 5265-66).

The Board followed up its oral determination of AMCS with a written Decision dated June 6, 2006. (Record at 5281-5300). In its written Decision, the Board found AMCS totaling "$42,270,000[1] for the second assessment year," consisting of the following:

[1] The Board's math notwithstanding, the categories of savings identified in its written Decision total $41,757,000, not $42,270,000.

a. CMAD ($14.5 million);

b. BD/CC ($2.7 million);

c. MaineCare Adults Expansion ($3.9 million);

d. Woodwork Effect ($57,000);

e. CON/CIF ($5.4 million);

e. PIP ($7.0 million); and

f. Increased Medicaid payments to physicians ($8.2 million).

(Record at 5281-5300).

The Board, therefore, approved for inclusion in its AMCS Determination every cost savings category advanced by Mercer, the DHA's consultant. (Record at 1397-1464, 5197-5270, 5281-5300). The only aspect of the Mercer Methodology that the Board did not accept root and branch was Mercer's proposed CMAD savings of $72.7 million (Record at 1439, 1442, 5242)—the Board instead approved only $14.5 million in CMAD savings. (Record at 5266, 5294).

ARGUMENT

I. THE BOARD HAS FORFEITED ITS ABILITY TO MAKE AN AMCS DETERMINATION BY FAILING TO MAKE SUCH A DETERMINATION BEFORE THE STATUTORY DEADLINE FOR DOING SO.

The Legislature clearly laid out the deadline for the Board to make its AMCS determination as follows:

> After an opportunity for hearing conducted pursuant to Title 5, chapter 375, subchapter 4, the board shall determine annually *not later than April 1st* the aggregate measurable savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. § 6913(1)(A) (emphasis added). There is no ambiguity in the statute—the Board must make its AMCS determination on or before April 1st.

Notwithstanding the Legislature's clear directive, the Board did not make its AMCS determination prior to the April 1, 2006 deadline for doing so. Instead, the Board made its determination on May 12, 2006, only after having been ordered by the Superior Court to do so. (Record at 671-79, 5197-5270).

The justification offered up by the DHA and accepted by the Board for ignoring the April 1, 2006 deadline is the notion that statutory deadlines are directory rather than mandatory. (Record at 166-68, 5272-74). However, the Law Court has held that statutory deadlines are directory rather than mandatory *only* in the absence of language evincing a contrary intention. See Bradbury Mem. Nursing Home v. Tall Pines Manor Assocs., 485 A.2d 634, 640 (Me. 1984). Here, there is language in the statute manifesting a contrary intention— "shall," a mandatory word, 1 M.R.S.A. § 71(9-A), and "not later than." Indeed, the statute could not be clearer. The Board simply does not have the power to ignore the Legislature's express mandate, and it has now lost its chance to make a determination of AMCS for the Second Assessment Year.

II. THE BOARD'S DETERMINATION IS BASED ON A DEFINITION OF AMCS THAT HAS NO STATUTORY BASIS.

A. AMCS Does Not Include Every Category Of Cost Savings Having Some Remote Connection To The Act.

At the core of this proceeding is the following statutory language:

> [T]he [Dirigo] Board shall determine annually … the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004.

24-A M.R.S.A. § 6913(1)(A). The Act, therefore, clearly and unambiguously provides that there are but two sources of "aggregate measurable cost savings"—cost savings as a result of "the operation of Dirigo Health" and cost savings as a result of increased MaineCare enrollment due

to expansions in eligibility. It is clear, however, that the Mercer Methodology approved by the Board includes within AMCS savings that are not "as a result of the operation of Dirigo Health."

As they did in the proceedings for the First Assessment Year, Mercer and others associated with the DHA have read the phrase "as a result of the operation of Dirigo Health" expansively to enable the Board to include within "aggregate measurable cost savings" all savings "as a result of the Dirigo Health Reform Act and its related initiatives." (Record at 1399, 1400, 1403, 1404, 1405, 1406, 1425, 3040, 5001, 5010, 5040, 5048). Mr. Schramm was quite clear in his testimony that Mercer sought to determine the existence of savings attributable to the Act, rather than those attributable to the operations of DHA:

> Mercer assisted the Dirigo Health Agency establish the methodologies to be used for determining if there was [sic] any savings associated with Year 2 of the Dirigo program, *including Dirigo's directly and indirectly related components*, as described in the Dirigo Health Reform Act and related amendments. Our work with the Agency included examining the statute, cataloging the various impacts of Dirigo and *Dirigo-related activities*, identifying the assorted populations and time frames impacted, and finally recommending proposed methodologies to capture those impacts.

(Record at 1255) (emphasis added). Thus, the foundation on which the Mercer Methodology rests is the notion that any cost savings having *any relationship to the Act* are appropriately considered in determining aggregate measurable cost savings.

As noted above, however, the Act requires that in order to be included in the calculation of AMCS, the measure must be "as a result of the operation of Dirigo Health." Under the Act, "Dirigo Health" is "an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents and individuals on a voluntary basis." 24-A M.R.S.A. § 6902. Thus, as used in the Act, "Dirigo Health" refers to the *agency* created by the Act, *i.e.*, the DHA, not to the Act. In the calculation of AMCS, therefore, the focus must be on

the agency alone, not the Act itself. The Board, the DHA, and Mercer are incapable or simply unwilling to recognize this distinction.

B. Most Of The Categories Of Cost Savings Approved By The Board Do Not Result From DHA's Operations.

It is not enough for a measure of cost savings to be related to the DHA to be considered in the calculation of AMCS; rather to be included in the calculation, an item of cost savings must be related to the *operation* of the DHA. A central tenet of statutory construction is that statutes must be interpreted in accordance with the plain meaning of the language used. See In re Wage Payment Litig., 2000 ME 162, ¶ 4, 759 A.2d 217, 220-21. The plain meaning of "operation" is the state of being functional. See THE NEW WEBSTER'S ENCYCLOPEDIC DICTIONARY OF THE ENGLISH LANGUAGE at 467-68 (1997). Therefore, in order to be properly included in the measure of AMCS, a cost savings must be attributable to the functioning of the DHA. The majority of the cost savings categories included in the Board's AMCS Determination do not satisfy this requirement.

1. CMAD

In its original form, the Act asked various participants in Maine's health care market to adhere to certain voluntary limits on their businesses. Among the requests, the Legislature asked hospitals to limit their cost increases to no more than 3.5% as measured by expenses per CMAD. See P.L. 2003, ch. 469, § F-1(1)(B). The original voluntary CMAD target expired on June 30, 2004. Id. Although the Legislature has set a new voluntary CMAD target of 110% of the forecasted increase in the hospital market basket index, that target applies only to fiscal years beginning *on or after* July 1, 2005. See P.L. 2005 ch. 394, § 4. In short, the Act contains voluntary CMAD targets for the First and Third Assessment Years, but not for the Second. (Record at 4130, 5147). This was no accident; the Legislature knew what it was doing. The year

under review here, and the period for which Mercer measured supposed CMAD savings, however, is July 1, 2004 through June 30, 2005. There is, therefore, no statutory voluntary CMAD target applicable to the year under review.

Undeterred, Mercer continues to pound the square peg into the round hole by including in its Methodology savings allegedly attributed to hospital adherence to a *voluntary* 4.5% CMAD target established in a June 16, 2004 press release by the Maine Hospital Association for July 1, 2004 through June 30, 2005. (Record at 1260, 1266, 1288-90, 1400, 1406). The inclusion of CMAD in the absence of a statutory basis is improper for two reasons.

First, Mercer's inclusion of CMAD in its Methodology is inconsistent with the stated premise on which its methodology rests. As articulated by Mercer, a category of savings is properly includable in the determination of AMCS if it has some relation *to the Act*. (Record at 1255, 1258, 1406). As noted above, and in contrast to both the immediately preceding and succeeding assessment years, the Act contains *no* voluntary CMAD target applicable to *this* assessment year. One cannot, in one breath, argue that AMCS includes those savings related in any way to the Act, and, in the next, argue that AMCS includes a savings category whose prior textual basis in the Act has been removed. For the Second Assessment Year, therefore, CMAD is not even related to the Act, much less related to DHA's operations.[2]

Second, Steven Michaud, the President of the Maine Hospital Association ("MHA"), emphatically testified that the voluntary 4.5% limit on CMAD was not related to the DHA or the Act. (Record at 4309, 4310-11, 5144, 5147, 5148, 5149). Indeed, the MHA and its members

[2] The record reflects some disagreement between Mercer and the DHA's counsel in terms of the propriety of including CMAD in AMCS given the lack of statutory authorization. From Mercer's notes of a telephone conversation with counsel for the DHA it appears that counsel was of the position that CMAD was not a proper measure of cost savings for the Second Assessment Year given the removal of the voluntary CMAD target from the Act, while Mercer argued that inclusion of CMAD was proper due to voluntary efforts by hospitals and the MHA press release. (Record at 3026).

have been interested in cost containment initiatives, including those with voluntary limits, since before the Act. (Record at 4310, 5150).

2. The Woodwork Effect

As conceived by Mercer, the savings from increased MaineCare enrollment may properly be included in AMCS in two ways—(1) due to expansions in MaineCare eligibility; and (2) due to the so-called "Woodwork Effect" of the previously uninsured or underinsured coming "out of the woodwork" to enroll in MaineCare "through the Dirigo single-point-of-entry enrollment process." (Record at 1250, 1261-62, 1416).

As noted above, one permissible element of cost savings for inclusion in the Dirigo Board's determination of aggregate measurable cost savings consists of cost savings attributable to "any increased MaineCare enrollment *due to an expansion in MaineCare eligibility* occurring after June 30, 2004." 24-A M.R.S.A. § 6913(1)(A) (emphasis added). Mercer, however, bases its Woodwork Effect savings on the increase in the number of persons enrolled in MaineCare due simply to *publicity* surrounding Dirigo (Record at 1247, 1248, 1261, 1401, 1416, 1417, 1420, 4977), rather than on the increase in MaineCare enrollment attributable to an expansion of MaineCare *eligibility* as required by the express language of the Act. In so doing, Mercer improperly ignores the limitation "due to an expansion in MaineCare eligibility." See Handyman Equip. Rental Co., Inc. v. City of Portland, 1999 ME 20, ¶ 9, 724 A.2d 605, 607-608 (meaning must be given to every word, term, and phrase in a statute).

Mercer originally planned to include in its methodology savings attributable to increased enrollment in private health insurance plans due to publicity surrounding Dirigo—so-called "private woodwork" savings. (Record at 1406, 1416). According to Messers. Russell and Schramm, private woodwork savings were not included in the Mercer Methodology due to the

unavailability of up-to-date data. (Record at 1247, 1262). Mercer's disingenuousness, however, knows no bounds. The record, including Mercer's *own internal communications* reveals that the evidence is that the Private Woodwork Effect is negative, *i.e.*, as public insurance goes up private insurance goes down. (Record at 3264, 3442, 4990, 5014). The Mercer methodology, however, does not account for this "crowding out" of private insurance. (Record at 4990, 5015). It is clear, therefore, that Mercer tried to bury the issue and left private woodwork out of its Methodology not because of a lack of data, but because it did not like what the data revealed. Indeed, at no point has Mercer shied away from including in its Methodology cost savings based on incomplete data. (Record at 1397-1464).

3. CON/CIF

Mercer includes in its methodology so-called CON/CIF savings. Those savings were calculated based on four hospitals that, purportedly because of Dirigo, withdrew their CON applications after revising their proposed projects so that their third-year operating expenses fell below the $400,000 CON review threshold. The savings were calculated by subtracting the $400,000 review threshold from the projects' original third-year operating expenses, reducing those amounts to present value, and applying the CIF spending limit. (Record at 1273, 1278, 1446, 5032). Such savings are not attributable to the operation of the DHA.

The Act does not create the CON process (Record at 5033), rather, the CON process was created by a statute that predates the Act, see P.L. 1977, ch. 687 (effective March 30, 1978) (CON statute); P.L. 2001, ch. 664, § 2 (effective July 25, 2002) ($400,000 threshold); P.L. 2003, ch. 469 (effective September 18, 2003) (the Act), the CON process is administered by the Department of Health & Human Services ("DHHS"), not the DHA (Record at 5033); and the $400,000 project review threshold is not a part of the Act and, in fact, predates the Act. (Record

at 5033, 5035). Cost savings from a program that predates the Act and that is administered by a different agency simply cannot be the result of the DHA's operation.

4. Budget Initiatives

Included within the Mercer Methodology approved by the Board are purported savings attributed to so-called "budget initiatives," consisting of the time value of money stemming from hospitals' receipt of increased PIP payments "early," and increased Medicaid payments. (Record at 1273-74, 1403, 1425-26, 1448, 1463, 5093). To justify the inclusion of the budget initiatives in its methodology, Mercer hangs its hat on the fact that the State made the PIP payments and the increased Medicaid payments based on the recommendations made by the Commission to Study Maine's Community Hospitals (the "Hospital Commission"), which was created by the Act.[3] (Record at 5007, 5008-5009, 5011). Specifically, the Hospital Commission recommended in pertinent part:

> 6. … MaineCare financing was also addressed with recognition that the State's budget would have great difficulty accommodating increases at this time. However, the State is urged to increase Medicaid payments to physicians as soon as possible and to hospitals over the next few years to cover the costs.
>
> 7. Urge Maine's Legislature to budget to pay past obligations to hospitals in a timely manner and reuse future periodic interim payment (PIP) estimates to include realistic future costs of Medicaid utilization increases.

(Record at 3891, 5007). This approach is fundamentally flawed in several respects.

First, the Hospital Commission is independent of DHA, and, in fact, DHA is not even referenced in the part of the Act in which the Hospital Commission was created. See P.L. 2003, ch. 469, Pt. F.

Second, at the time the Act was passed in 2003, there was no guarantee that the Hospital Commission would even make recommendations on the Budget Initiatives, much less make the

[3] The Hospital Commission was created by P.L. 2003, ch. 469, § F-3(1).

recommendations that it did. Nor was it by any means clear that, whether for political reasons or for the budgetary constraints to which the Hospital Commission itself referred, the Legislature would actually appropriate the funds necessary to carry out the recommendations. Indeed, Rebecca Wyke, the Commissioner of the Maine Department of Administrative & Financial Services and the State's Chief Financial Officer (Record at 1252, 5007), testified that the budget initiatives were considered for inclusion in the budget during very difficult times because they impacted a significant initiative that the Governor had put forth and therefore were a priority for funding. (Record at 5012). Thus, the fact that the payments recommended by the Hospital Commission were made by the State has nothing to do with the passage of the Act three years earlier, and everything to do with the political and budgetary priorities of the Governor and a majority of the Legislature.

Third, the savings attributed to the PIP payments are not based on the receipt of the underlying payments, but on the time value associated with the hospitals' receipt of those payments "early." (Record at 5097). The time value of money, therefore, is based on the timing of the payments. The Hospital Commission, however, did not address the timing of PIP payments. The only connection between the Act and the timing of the PIP payments is Commissioner Wyke's testimony that she was cognizant of the Act at the time the funds for the payment were budgeted. (Record at 1253). Thus the causal chain is as follows:

1. The Act created the Hospital Commission;

2. Although it did not have to, the Hospital Commission chose to recommend that the State make the payments;

3. Although he did not have to, the Governor included money to fund the recommended payments in his budget;

4. Although it did not have to, the Legislature chose to appropriate the money necessary to fund the recommended payments; and

5. Although it did not have to the State chose to make the payments "early" because it was thinking about the Act.

There are, therefore, four intervening discretionary events between the Act's creation of the Hospital Commission in 2003 and the hospitals' receipt of the settlement and PIP payments in 2006.

Fourth, the PIP payments and increased Medicaid payments are made in connection with the federal Medicaid program (known in Maine as "MaineCare"). The DHA, however, is not the single state agency authorized by the federal government to administer the Medicaid programs in Maine; that distinction belongs to DHHS. (Record at 5052). Thus, DHHS, a separate agency, operates the Medicaid program in Maine. (Record at 5008, 5052). In fact, PIP payments were not created by the Act or the DHA, and DHHS sets the PIP payment rates. (Record at 1281, 5052, 5054, 5055).

Finally, unless DHA is now responsible for interest and inflation, the time value of money has nothing more to do with the operation of the DHA than do the payments on which they were based.

III. THE LACK OF CONSISTENCY IN THE TIME PERIODS FOR WHICH COST SAVINGS APPROVED BY THE BOARD ARE CALCULATED RESULTS IN AN INFLATED AMCS AMOUNT.

Since the Board is charged with making an AMCS determination "annually," one would reasonably assume that the Mercer Methodology adopted by the Board measures each element of cost savings included within that determination for the same 12-month period. That, however, is not the case. Instead, the Mercer Methodology uses a hodge-podge of three different time periods spanning 30 months to calculate the savings attributable to the various cost savings

categories approved by the Board. The result of selecting the time period for measuring AMCS cost savings categories from the *a la carte* menu is an inflated AMCS figure.

A. Only One Of The Time Periods Measured By Mercer Actually Corresponds To The Second Assessment Year Under Review Here.

The time period for which each of the cost savings categories advanced by Mercer were calculated are as follows:

SAVINGS CATEGORY	TIME PERIOD MEASURED
CMAD	July 1, 2004 – June 30, 2005
BD/CC	January 1, 2006 – December 31, 2006
MaineCare Adults Expansion	July 1, 2005 – December 31, 2006
Woodwork Effect	July 1, 2005 – December 31, 2006
CON/CIF	January 1, 2006 – December 31, 2006
PIP	January 1, 2006 – December 31, 2006
Increased Medicaid Payments	January 1, 2006 – December 31, 2006

(Record at 1259, 1266, 1274, 1401, 1413-14, 1417, 1426, 1441, 1444, 1446, 1453, 1454-55, 1457, 1461, 1463, 2923, 4977, 4979, 4980, 4999, 5007, 5008, 5010, 5045, 5047, 5049, 5050, 5095).

Under review, here, is the Second Assessment Year, *i.e.*, July 1, 2004 through June 30, 2005. However, only the purported cost savings attributable to CMAD correspond to this time period. The other savings categories should be ignored simply because they are based on the wrong time period.

B. Manipulating The Time Periods Results In Double Counting.

1. CON/CIF

Mercer's Methodology contains no control to ensure that there is no duplication between the savings attributed to CMAD and those attributed to CON/CIF. (Record at 3036). In fact, the

CON/CIF savings calculated by Mercer for CY 2006 will necessarily be embedded in a future CMAD calculation—a fact Mr. Schramm readily acknowledges. (Record at 4314, 5143). According to Mr. Schramm, such is not double counting because the time frame for which Mercer calculated CMAD (SFY 2005) differs from the time frame used to calculate CON/CIF (CY 2006). (Record at 5045, 5136). In other words, it is not double counting unless the time periods actually overlap. To those of us not getting paid under a $900,000 contract (Record at 3059), counting $10 dollars in savings in one year and counting it again two years later is double counting and unreasonable.

2. BD/CC

Mercer does not calculate BD/CC savings for the assessment year under review by determining savings attributable only to those who recently enrolled in DirigoChoice; that would not yield a high enough number. Instead, Mercer proposes to count as BD/CC savings in this assessment year, BD/CC savings attributed to every DirigoChoice enrollee who was previously un- or under-insured and to include that person in the BD/CC calculation every year that he is enrolled in DirigoChoice. (Record at 4984, 4997, 5005). In other words, although the BD/CC methodology it created purportedly quantifies BD/CC savings from those previously un- and under-insured, Mercer acknowledges that it is counting enrollees who were *already insured* (because the DHA insured them) long before the beginning of the assessment year in question.[4] This Enron-inspired accounting is patently absurd.

[4] Mercer does not look at each DirigoChoice enrollee individually to determine their prior insurance status, though given DirigoChoice's paltry enrollment it certainly could do so, rather, Mercer looks only at raw enrollment numbers each year.

IV. THE BOARD'S AMCS DETERMINATION IS BASED UPON ASSUMPTIONS HAVING NO FACTUAL SUPPORT IN THE RECORD.

Apparently in the hopes that if they incant the word enough times someone will actually believe it, Mercer refers to its Methodology and the assumptions on which it is based as being "conservative" *ad nauseum*. (Record at 1278, 1279, 1446, 1458, 1460, 4977, 4978, 4979, 4980, 4991, 4993, 5044, 5049, 5112).[5] The record reveals, however, that the assumptions on which several of the cost savings calculations are based are anything but conservative and have no factual basis in the record.

A. BD/CC

Mercer's BD/CC analysis is based in part on two unsubstantiated assumptions.

First, in calculating BD/CC, Mr. Russell assumed that there was $150 million of BD/CC related to hospitals and he further assumed that hospital BD/CC is 84% of all BD/CC in the system. (Record at 4981). Those assumptions were based on the work performed by Dr. Nancy Kane last year. (Record at 4981). Mr. Russell, however, did not similarly accept Dr. Kane's assumption that 46% of bad debt is attributable to the uninsured. (Record at 4981). Instead, Mr. Russell assumed that 50% of bad debt is attributable to the uninsured. (Record at 4981). Mr. Russell's 50% assumption is based on no documentation or independent analysis. (Record at 4981).[6]

So although he used Dr. Kane's work as the basis for his assumptions in other areas, Mr. Russell jettisoned her 46% assumption in favor of a 50% assumption having no factual basis. The result of the rejection of Dr. Kane's assumption was an increased BD/CC amount. (Record at 4981). The most Mr. Russell could say is that he simply rounded Dr. Kane's 46% assumption

[5] Included are references to the invocation of the talismanic term "conservative" by Catherine Cobb whose pre-filed testimony was prepared by Mercer. (Record at 5039).
[6] Mr. Russell's Ouija board has not yet been located.

up to 50%. (Record at 4991). Of course, Mr. Russell did not round down Dr. Kane's other assumptions.

Second, Mr. Russell did not calculate the number of underinsured people based on available information. (Record at 4989). Rather, Mr. Russell based his calculations on an assumption of 25% underinsured for which he has no supporting data. (Record at 4989).

B. The Woodwork Effect

Mercer's Woodwork Effect calculation is based on the assumption that 76 of MaineCare's new enrollees during the period of July 1, 2005 through December 31, 2006 were enrolled in MaineCare after it was discovered that they were so eligible while applying for coverage under Dirigo Choice. (Record at 1458, 4979). There is, however, no evidence to support this notion other than a vague assertion that some unidentified person associated with the DHA identified 76 such persons. (Record at 4979).

C. CON/CIF

The Mercer CON/CIF methodology is predicated on two assumptions: (1) that the four hospitals withdrew their CON applications because of Dirigo; and (2) each of the projects would have satisfied the CON need criteria. Neither assumption has any basis in reality.

First, as noted by Catherine Cobb, the DHHS official who supervises the CON program, and Steven Michaud, MHA's President, there are any number of reasons why a hospital might withdraw a CON application irrespective of Dirigo, including changes in the scope of a project, changes in projected construction costs, and advances in technology and treatment advances. (Record at 1276, 4313, 5031, 5036). Neither Ms. Cobb nor Mr. Schramm has any documentary evidence revealing why the four hospitals in question withdrew their CON applications nor did

either of them contact any of the hospitals in an attempt to verify the reasons for the withdrawals. (Record at 5040, 5046, 5050).

Second, Ms. Cobb, who supervises the CON program, has no idea whether all of the four projects in question would have been approved on the merits in terms of need. (Record at 5035). In fact, Ms. Cobb testified that she was aware of the battle between Inland Hospital and MaineGeneral Hospital that had materialized precisely because it was apparent that both projects would not be approved. (Record at 5041).[7]

D. PIP Payments

As was the case for the First Assessment Year, Mercer bases its calculation of the time value of money with respect to the PIP payments on the assumption that the PIP payments were received by hospitals 36 months early. (Record at 5095) ("We're assuming they're made 36 months earlier"). While the Superintendent found the 36-month estimate to be reasonable last year, the Superintendent based that conclusion on the supporting testimony of Ms. Wyke regarding the magnitude and timing of the increased PIP payments. (Record at 4617). In this proceeding, however, there is no comparable testimonial support from Ms. Wyke or anyone else.

CONCLUSION

For all of the foregoing reasons, the Superintendent should disapprove the Board's filing in its entirety.

[7] Mr. Schramm testified that he did not disagree with any of Ms. Cobb's testimony. (Record at 5045).

Dated: June 23, 2006

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that by 3:00 p.m. on June 23, 2006, I served the above filing on the following parties and counsel of record as follows:

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